INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE G. HEALTH COVERAGE AVAILABILITY

CHAPTER 1506. TEXAS HEALTH INSURANCE POOL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1506.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the pool.

(1-a) "Church plan" has the meaning assigned by Section 3(33), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(33)).

(1-b) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) a group health plan;

(B) health insurance coverage;

(C) Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.);

(D) Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(E) 10 U.S.C. Section 1071 et seq.;

(F) a medical care program of the Indian Health Service or a tribal organization;

(G) a state health benefits risk pool;

(H) a health benefits plan offered under 5 U.S.C. Section 8901 et seq.;

(I) a public health plan as defined in federal regulations;

(J) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or

(K) a state child health plan provided under Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.).

(1-c) "Federally defined eligible individual" means an individual:

(A) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is 18 months or more;

(B) whose most recent prior creditable coverage was under:

(i) a group health plan, governmental plan, or church plan; or

(ii) health insurance coverage offered in connection with a plan described by Subparagraph (i);

(C) who is not eligible for coverage under a group health plan, Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.), or a state plan under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or any successor program, and who does not have other health benefit plan coverage;

(D) with respect to whom the most recent coverage within the aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) who, if offered the option of continuation coverage under a continuation provision required by Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), or under a similar state program, elected that coverage; and

(F) who has exhausted continuation coverage, if elected, under Paragraph (E).

(1-d) "Governmental plan" has the meaning assigned by Section 3(32), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(32)), and includes any United States governmental plan.

(1-e) "Group health plan" means an employee welfare benefit plan as defined by Section 3(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)), to the extent that the plan provides health benefit plan coverage to employees or their dependents as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(2) "Health benefit arrangement" means a plan, program, contract, or other arrangement through which an employer provides health care services, other than health care services covered through a health benefit plan issuer, to the employer's officers, employees, or other personnel.

(3) "Health benefit plan issuer" means an entity that provides health benefit plan coverage in this state, including stop-loss or excess loss insurance. The term includes:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization;

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(G) an eligible surplus lines insurer operating under Chapter 981;

(H) an insurer providing stop-loss or excess loss insurance to physicians, health care providers, or hospitals or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and

(I) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Health maintenance organization" means an entity that holds a certificate of authority to operate under Chapter 843.

(5) "Hospital" means a hospital for which a license is issued under Chapter 241, Health and Safety Code, or that is owned or operated by the federal or state government.

(6) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(7) "Pool" means the Texas Health Insurance Pool.

(8) "Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have health benefit plan coverage, except that a waiting period or an affiliation period is not considered in determining a significant break in coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 1, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 1, eff. January 1, 2008.
Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 2, eff. September 1, 2009.

Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means an individual or group health benefit plan and includes:

(1) a hospital or medical expense incurred policy;

(2) coverage of medical or health care services offered by:

(A) a group hospital service corporation operating under Chapter 842;

(B) a fraternal benefit society operating under Chapter 885;

(C) a stipulated premium company operating under Chapter 884;

(D) a health maintenance organization;

(E) a multiple employer welfare arrangement subject to Chapter 846; or

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(3) any other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise.

(b) In this chapter, "health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only insurance;

(3) coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) workers' compensation or similar insurance;

(6) coverage for on-site medical clinics;

(7) automobile medical payment insurance;

(8) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; or

(9) other similar insurance coverage, specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) In this chapter, "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) limited scope dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or

(3) other similar, limited benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

(d) In this chapter, "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) coverage only for a specified disease or illness; or

(2) hospital indemnity or other fixed indemnity insurance.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 824, Sec. 1, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 2, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 2, eff. January 1, 2008.

Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a resident spouse or unmarried child younger than 25 years of age; or

(2) a child who is:

(A) a full-time student younger than 25 years of age who is financially dependent on the parent;

(B) 18 years of age or older and is an individual for whom a person may be obligated to pay child support; or

(C) disabled and dependent on the parent regardless of the age of the child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state auditor may conduct a special audit of the pool under Chapter 321, Government Code. The special audit may include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller. The board shall remit that amount to the comptroller.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.065(a), eff. September 1, 2005.

Sec. 1506.005. RULES. The commissioner may adopt rules necessary and proper to implement this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board.

(b) The grievance committee shall report to the board after completion of the review of each complaint.

(c) The board shall retain each written complaint concerning the pool at least until the third anniversary of the date the pool received the complaint.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A health benefit plan issuer may provide to its insureds and enrollees a notice relating to the existence of the pool that contains the address from which an insured or enrollee may obtain information about the coverage offered by the pool, the eligibility for and cost of the coverage, and other information that allows an insured or enrollee to compare the issuer's health benefit plan coverage provided to the insured or enrollee with the coverage offered by the pool.

(a-1) A health benefit plan issuer, employer, or other person who is required to provide notice to an individual of the individual's ability to continue coverage in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), shall, at the time that that notice is required, also provide notice to the individual of the availability of coverage under the pool.

(a-2) A health benefit plan issuer who is providing coverage to an individual in accordance with Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), shall, not later than the 45th day before the date that coverage expires, notify the individual of the availability of coverage under the pool.

(b) A health benefit plan issuer providing notice under this section shall provide the notice as prescribed by the commissioner.

(c) A health benefit plan issuer does not incur any liability solely for providing notice under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2007, 80th Leg., R.S., Ch. 997, Sec. 16, eff. September 1, 2007.

Sec. 1506.008. EXEMPTION FROM STATE TAXES AND FEES. The pool is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 3, eff. June 30, 2007.

For expiration of this section, see Subsection (d).

Sec. 1506.009. STUDY; REPORT. (a) The commissioner shall conduct a study concerning a program under which the pool would offer coverage to an individual who is also covered under a group health benefit plan that is provided or offered to the individual through an employer. Under the proposed program, pool coverage would be secondary to coverage provided under the group health benefit plan.

(b) The commissioner, using existing resources, may contract with actuaries and other experts as necessary to conduct the study.

(c) The commissioner shall report the results of the study in the biennial report under Section 32.022. The report must:

(1) include an analysis of the advantages and disadvantages of the proposed program and recommended minimum standards applicable to group health benefit plans that may be included in the program; and

(2) identify program components, requirements, or restrictions necessary for successful implementation of the program.

(d) This section expires September 1, 2009.

Added by Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 3, eff. June 30, 2007.

Sec. 1506.010. REDESIGNATION. Effective September 1, 2009, the Texas Health Insurance Risk Pool is redesignated the Texas Health Insurance Pool. A reference in any law to the Texas Health Insurance Risk Pool means the Texas Health Insurance Pool.

Added by Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 3, eff. September 1, 2009.

SUBCHAPTER B. BOARD OF DIRECTORS

Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of directors.

(b) The board consists of nine members appointed by the commissioner as follows:

(1) at least two, but not more than four, members must be individuals who are affiliated with a health benefit plan issuer authorized to write health benefit plans in this state;

(2) at least two of the members must be individuals or the parents of individuals who are covered by the pool or are reasonably expected to qualify for coverage by the pool; and

(3) the other members of the board may be selected from individuals such as:

(A) a physician licensed to practice in this state by the Texas State Board of Medical Examiners;

(B) a hospital administrator;

(C) an advanced nurse practitioner; or

(D) a representative of the public who is not employed by or affiliated with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization.

(c) For purposes of Subsection (b), an individual who is required to register under Chapter 305, Government Code, because of the individual's activities with respect to health benefit plan-related matters is affiliated with a health benefit plan issuer.

(d) An individual is not disqualified under Subsection (b)(3)(D) from representing the public if the individual's only affiliation with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization is as an insured or as an individual who has coverage through a plan provided by the corporation or organization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728, Sec. 11.066(a), eff. September 1, 2005.

Sec. 1506.052. PRESIDING OFFICER. The commissioner shall designate one member of the board to serve as presiding officer at the pleasure of the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.053. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms.

(b) The commissioner shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the appropriate qualifications to fill that position.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the board is entitled to:

(1) a per diem in the amount provided by the General Appropriations Act for state officials for each day the member performs duties as a board member; and

(2) reimbursement of expenses incurred while performing duties as a board member in the amount provided by the General Appropriations Act for state officials.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the board is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust deductibles, the amounts of stop-loss coverage, and the periods governing preexisting conditions under Section 1506.155 to preserve the financial integrity of the pool.

(b) Not later than the 30th day after the date the board makes an adjustment under this section, the board shall submit to the commissioner a written report containing a description of and the reasons for the adjustment.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not later than June 1 of each year, the board shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the commissioner.

(b) The report must summarize the activities of the pool in the calendar year preceding the year in which the report is submitted and must include information relating to net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The commissioner by rule may establish powers and duties of the board in addition to those provided by this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER C. POWERS AND DUTIES OF POOL

Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the pool are to:

(1) provide for access to quality health care at minimum cost to the public;

(2) relieve the insurable population of the disruptive cost of sharing coverage; and

(3) maximize reliance on strategies of managed care proven by the private sector.

(b) The pool is not intended to diminish the availability of traditional health care coverage to consumers who are eligible for that coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.

(b) The pool may appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in operating the pool and performing any of the functions of the pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may provide health benefit coverage to an individual who is eligible for that coverage under this chapter.

(b) The pool may issue health benefit coverage subject to this chapter and the pool's plan of operation under Section 1506.201.

(c) The pool may issue additional types of health benefit coverage to provide optional coverages that comply with applicable provisions of state and federal law, including a Medicare supplement benefit plan for individuals 65 years of age or older who are eligible for Medicare.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728, Sec. 11.067(a), eff. September 1, 2005.

Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool may establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform actuarial functions appropriate to the operation of the pool.

(b) The pool may adopt policy forms, endorsements, and riders and applications for coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.105. PREMIUM RATES. (a) The pool may not charge premium rates that are unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(c) Premium rates and premium rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs. The pool may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(d) The pool shall establish the standard risk rate. In establishing the rate, the pool shall use reasonable actuarial techniques and consider the premium rates charged by other health benefit plan issuers offering health benefit coverage to individuals. The rate must reflect anticipated experience and expenses for health benefit coverage.

(e) Premium rates shall be established to provide fully for all of the expected costs of claims, including recovery of prior losses, expenses of operation, investment income from claim reserves, and any other cost factors, subject to the limitations described in this subsection and Subsection (e-1). In no event may pool premium rates exceed 200 percent of the standard risk rate described by Subsection (d).

(e-1) Subject to the availability of funds under Section 1506.260, discounted premiums shall be offered on a sliding scale, based on financial need, as follows:

(1) for an individual whose household income is below 200 percent of the federal poverty measure, determined under the United States Department of Health and Human Services poverty guidelines in effect at the time coverage is provided, premium rates shall equal the standard risk rate described by Subsection (d); and

(2) for an individual whose household income is at or below 300 percent, but not less than 200 percent, of the federal poverty measure, determined under the United States Department of Health and Human Services poverty guidelines in effect at the time coverage is provided, premium rates shall equal 140 percent of the standard risk rate described by Subsection (d).

(f) The pool shall submit each rate and rate schedule to the commissioner for approval. The pool may not use a rate or rate schedule before the rate or schedule is approved by the commissioner. In evaluating a rate or rate schedule of the pool, the commissioner shall consider the factors provided by this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.068(a), eff. September 1, 2005.
Acts 2009, 81st Leg., R.S., Ch. 265, Sec. 3, eff. January 1, 2010.

Sec. 1506.106. REINSURANCE. The pool may provide for reinsurance on a facultative or treaty basis or on both facultative and treaty bases.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.107. CONTRACTS. (a) The pool may enter into a contract that is necessary to carry out this chapter, including, with the approval of the commissioner, a contract with:

(1) a similar pool in another state for the joint performance of common administrative functions; or

(2) another organization for the performance of administrative functions.

(b) The pool may contract for stop-loss insurance for risks incurred by the pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be sued.

(b) The pool may take any legal action necessary to:

(1) avoid payment of improper claims against the pool or the coverage provided by or through the pool; or

(2) recover or collect amounts due the pool, including:

(A) assessments due the pool;

(B) amounts erroneously or improperly paid by the pool; and

(C) amounts paid by the pool as a mistake of fact or law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.109. COST CONTAINMENT. (a) The pool shall provide for and use cost containment measures and requirements to make the coverage offered by the pool more cost-effective. To the extent the board determines it is cost-effective, the cost containment measures must include individual case management and disease management. The cost containment measures may include preadmission screening, the requirement of a second surgical opinion, and concurrent utilization review subject to Chapter 4201.

(b) The pool may design, use, contract for, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 824, Sec. 2, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 730, Sec. 2G.017, eff. April 1, 2009.

Sec. 1506.110. BORROWING. The pool may borrow money as necessary to implement the purposes of the pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the other powers granted to the pool under this chapter, the pool may exercise any of the authority that a health benefit plan issuer authorized to write health benefit plans in this state may exercise under the law of this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. POOL COVERAGE AND BENEFITS

Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall offer coverage consistent with major medical expense coverage to each eligible individual.

(b) The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(c) The benefits provisions of the pool's coverage must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the pool;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted.

(d) Coverage provided by the pool is subject to Chapter 1379.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:

Acts 2005, 79th Leg., Ch. 728, Sec. 11.069(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 3, eff. January 1, 2008.

Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 4, eff. January 1, 2008.

Acts 2009, 81st Leg., R.S., Ch. 719, Sec. 2, eff. September 1, 2009.

Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An individual who is a legally domiciled resident of this state is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual is a federally defined eligible individual who has not experienced a significant break in coverage;

(2) is younger than 65 years of age and provides to the pool evidence that the individual maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date the coverage described by this subdivision was terminated;

(3) is younger than 65 years of age and has been a legally domiciled resident of this state for the preceding 30 days, is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years, and provides to the pool:

(A) a notice of rejection of, or refusal to issue, substantially similar individual health benefit plan coverage from a health benefit plan issuer, other than an insurer that offers only stop-loss, excess loss, or reinsurance coverage, if the rejection or refusal was for health reasons;

(B) certification from an agent or salaried representative of a health benefit plan issuer that states that the agent or salaried representative cannot obtain substantially similar individual coverage for the individual from any health benefit plan issuer that the agent or salaried representative represents because, under the underwriting guidelines of the health benefit plan issuer, the individual will be denied coverage as a result of a medical condition of the individual;

(C) an offer to issue substantially similar individual coverage only with conditional riders;

(D) a diagnosis of the individual with one of the medical or health conditions on the list adopted under Section 1506.154; or

(E) evidence that the individual is covered by substantially similar individual coverage that excludes one or more conditions by rider; or

(4) provides to the pool evidence that, on the date of application to the pool, the individual is certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance, as provided by the Trade Adjustment Assistance Reform Act of 2002 (Pub. L. No. 107-210).

(b) Subject to Subsection (f), each dependent of an individual who is eligible for coverage from the pool is also eligible for coverage from the pool.

(c) Subject to Subsection (f), if an individual who obtains coverage from the pool under Subsection (a) is a child, each parent, grandparent, brother, sister, or child of that individual who resides with that individual is also eligible for coverage from the pool.

(d) The board shall develop a form to be used for certification under Subsection (a)(3)(B). Before it may be used, the form must be approved by the commissioner.

(e) Notwithstanding Sections 1506.153(a)(1)-(6), an individual who is certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance, as provided by the Trade Adjustment Assistance Reform Act of 2002 (Pub. L. No. 107-210), and who has at least three months of prior health benefit plan coverage, as described by Section 1506.155(d), is not required to exhaust any benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.), as amended (COBRA), or state continuation benefits to be eligible for coverage from the pool.

(f) A dependent or individual described by Subsection (c) who is not a federally defined eligible individual and who has not experienced a significant break in coverage may not obtain coverage from the pool before the first date on which the dependent or individual has been:

(1) a legally domiciled resident of this state for at least the 30 days preceding the date of the application for coverage from the pool; and

(2) a citizen or permanent resident of the United States for at least three continuous years.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.070(a), eff. September 1, 2005.
Acts 2005, 79th Leg., Ch. 824, Sec. 3, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 4, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 5, eff. January 1, 2008.
Acts 2009, 81st Leg., R.S., Ch. 87, Sec. 14.013, eff. September 1, 2009.
Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 4, eff. September 1, 2009.

Sec. 1506.153. INELIGIBILITY FOR COVERAGE. (a) Notwithstanding Section 1506.152, an individual is not eligible for coverage from the pool if:

(1) on the date pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect, except as provided by Section 1506.152(a)(3)(E);

(2) at the time the individual applies to the pool, except as provided in Subsection (b), the individual is eligible for other health care benefits, including an offer of benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), other than:

(A) coverage, including COBRA or other continuation coverage or conversion coverage, maintained for any preexisting condition waiting period under a pool policy or during any preexisting condition waiting period or other waiting period of the other coverage;

(B) employer group coverage conditioned by a limitation of the kind described by Section 1506.152(a)(3)(A) or (C); or

(C) individual coverage conditioned by a limitation described by Section 1506.152(a)(3)(C) or (D);

(3) within 12 months before the date the individual applies to the pool, the individual terminated coverage in the pool, unless the individual:

(A) demonstrates a good faith reason for the termination; or

(B) is a federally defined eligible individual;

(4) the individual is confined in a county jail or imprisoned in a state or federal prison;

(5) any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider;

(6) the individual's prior coverage with the pool was terminated:

(A) during the 12-month period preceding the date of application for nonpayment of premiums; or

(B) for fraud; or

(7) the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined. This subdivision does not apply to an individual who is a part-time employee or a part-time employee's dependent eligible to participate in an employer plan that provides health benefit coverage:

(A) that is more limited or restricted than coverage with the pool; and

(B) for which there is no employer contribution to the premium, either directly or indirectly.

(b) An individual eligible for benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), or a comparable federal or state employee coverage continuation program, who did not elect continuation of coverage during the election period, or whose elected continuation of coverage lapsed or was cancelled without reinstatement, is eligible for pool coverage. Eligibility under this subsection is subject to a minimum 180-day exclusion of coverage under Section 1506.155(a-1).

(c) An individual eligible for benefits from the continuation of coverage under Subchapter F or G, Chapter 1251, or Subchapter G, Chapter 1271, who did not elect continuation coverage during the election period, or whose elected continuation coverage lapsed or was canceled without reinstatement, is eligible for pool coverage. Eligibility under this subsection is subject to a 180-day exclusion of coverage under Section 1506.155(a-1).

(d) The 180-day exclusion of coverage provided under Subsection (c) does not apply to an individual eligible for benefits from the continuation of coverage under Subchapter F or G, Chapter 1251, or Subchapter G, Chapter 1271, who did not elect continuation coverage during the election period, or whose elected continuation coverage lapsed or was canceled without reinstatement, following a period of continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.071(a), eff. September 1, 2005.
Acts 2005, 79th Leg., Ch. 824, Sec. 4, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 5, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 6, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 1070, Sec. 2, eff. June 15, 2007.
Reenacted and amended by Acts 2009, 81st Leg., R.S., Ch. 87, Sec. 14.014, eff. September 1, 2009.
Reenacted and amended by Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 5, eff. September 1, 2009.
Amended by:
Acts 2009, 81st Leg., R.S., Ch. 550, Sec. 9, eff. June 19, 2009.

Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board shall adopt a list of medical or health conditions for which an individual is eligible for pool coverage under Section 1506.152(a)(3)(D) without applying for health benefit plan coverage.

(b) The board may amend the list as appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 6, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 7, eff. January 1, 2008.

Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as provided by this section and Section 1506.056, pool coverage excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which:

(1) the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the six-month period preceding the effective date of coverage; or

(2) medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

Text of subsection as amended by Acts 2009, 81st Leg., R.S., Ch. 550, Sec. 10

(a-1) Except as provided by Section 1506.056, pool coverage for an individual eligible pursuant to Section 1506.153(b) or (c) excludes charges or expenses incurred before the expiration of 180 days from the effective date of coverage with regard to any condition for which:

(1) the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the six-month period preceding the effective date of coverage; or

(2) medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

Text of subsection as amended by Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 6

(a-1) Except as provided by Section 1506.056, pool coverage for an individual eligible pursuant to Section 1506.153(b) excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which:

(1) the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the six-month period preceding the effective date of coverage; or

(2) medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) The exclusion provided by Subsection (a) does not apply to a federally defined eligible individual or an individual who:

(1) was continuously covered for a period of at least 12 months, excluding any waiting period, by creditable coverage that terminated not earlier than the 63rd day before the effective date of coverage under the pool; and

(2) applied for pool coverage not later than the 63rd day after the date the creditable coverage described by Subdivision (1) terminated.

(c) If an individual was covered by creditable coverage that was in effect at any time during the 12-month period preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that creditable coverage and any waiting period that applied before that creditable coverage became effective.

(c-1) If an individual eligible under Section 1506.153(b) was covered by creditable coverage at any time during the 12-month period immediately preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a-1) up to 180 days of:

(1) the period during which the individual was covered under the creditable coverage; and

(2) any waiting period that applied before the creditable coverage became effective.

(d) A preexisting condition provision may not be applied to an individual who has been certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance, as provided by the Trade Adjustment Assistance Reform Act of 2002 (Pub. L. No. 107-210), if the individual:

(1) was continuously covered by a health benefit plan for a period of three months before the individual's separation from employment; and

(2) applies for coverage from the pool not later than the 63rd day after the date on which the prior coverage was terminated.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.071(b), eff. September 1, 2005.
Acts 2005, 79th Leg., Ch. 824, Sec. 5, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 7, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 8, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 1070, Sec. 3, eff. June 15, 2007.
Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 6, eff. September 1, 2009.
Acts 2009, 81st Leg., R.S., Ch. 550, Sec. 10, eff. June 19, 2009.

Sec. 1506.156. BENEFIT REDUCTION; CERTAIN COVERAGES SECONDARY. (a) The pool shall reduce benefits otherwise payable under pool coverage by:

(1) the total amount paid or payable through any other health benefit plan or health benefit arrangement; and

(2) the total amount of hospital or medical expense benefits paid or payable under:

(A) workers' compensation coverage;

(B) automobile insurance, regardless of whether provided on the basis of fault or no fault; or

(C) a state or federal law or program.

(b) Pool coverage provided under Section 1506.152(a)(3)(E) is secondary to the individual coverage described by that paragraph for any period during which that individual coverage is in effect.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 824, Sec. 6, eff. January 1, 2006.

Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool has a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses.

(b) Benefits due from the pool may be reduced or refused as an offset against an amount recoverable under this section.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An individual's pool coverage ends:

(1) on the date the individual ceases to be a legally domiciled resident of this state, unless the individual:

(A) is a student younger than 25 years of age and is financially dependent on a parent covered by the pool;

(B) is a child for whom an individual covered by the pool may be obligated to pay child support; or

(C) is a child who is disabled and dependent on a parent covered by the pool, regardless of the age of the child;

(2) on the first day of the month following the date the individual requests coverage to end;

(3) on the date the individual covered by the pool dies;

(4) on the date state law requires cancellation of the coverage;

(5) at the option of the pool, on the 31st day after the date the pool sends to the individual any inquiry concerning the individual's eligibility, including an inquiry concerning the individual's residence, to which the individual does not reply;

(6) on the 31st day after the date a premium payment for pool coverage becomes due if the payment is not made before that day;

(7) on the date the individual is 65 years of age and eligible for coverage under Medicare, unless the coverage received from the pool is Medicare supplement coverage issued by the pool; or

(8) at the time the individual ceases to meet the eligibility requirements for coverage.

(b) Notwithstanding Subsection (a), the coverage of an individual who ceases to meet the eligibility requirements for coverage terminates on the earlier of:

(1) the first premium due date after the date the pool determines the individual does not meet the eligibility requirements; or

(2) the first day of the first month after the month in which the pool determines the individual does not meet the eligibility requirements.

(c) The pool has the sole discretion to determine that an individual does not meet the eligibility requirements for coverage.

(d) An individual may maintain pool coverage for the period the individual is satisfying a preexisting waiting period under another health benefit plan or health benefit arrangement intended to replace the pool coverage.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 728, Sec. 11.071(c), eff. September 1, 2005.

Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health benefit plan issuer, agent, third-party administrator, or other person authorized or licensed under this code may not arrange or assist in, or attempt to arrange or assist in, the application for coverage from or placement in the pool of an individual who is not

eligible under Section 1506.153(a)(7) for coverage from the pool for the purpose of separating the person from health benefit plan coverage offered or provided in connection with employment that would be available to the person as an employee or a dependent of an employee.

(b) A violation of this section is an unfair method of competition and an unfair or deceptive act or practice under Chapter 541.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2009, 81st Leg., R.S., Ch. 87, Sec. 14.015, eff. September 1, 2009.

SUBCHAPTER E. OPERATION OF POOL

Sec. 1506.201. PLAN OF OPERATION. (a) Operation and management of the pool is governed by a plan of operation. The plan of operation includes the articles, bylaws, and operating rules of the pool that are adopted by the board.

(b) The plan of operation must ensure the fair, reasonable, and equitable administration of the pool.

(c) In addition to complying with the other requirements of this chapter, the plan of operation must include procedures for:

(1) operation of the pool;

(2) selection of an administrator as provided by Section 1506.202;

(3) creation of a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) development and implementation of a program to:

(A) publicize the existence of the pool, the eligibility requirements for coverage under the pool, and enrollment procedures; and

(B) foster public awareness of the pool;

(6) creation of a grievance committee to review complaints presented by applicants for coverage from the pool and individuals who are covered by the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this chapter.

(d) The board shall amend the plan of operation as necessary to carry out this chapter. An amendment to the plan of operation must be approved by the commissioner before it becomes a part of the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may, on a competitive bid basis, contract with one or more health benefit plan issuers or third-party administrators authorized by the department to administer the pool.

(b) The board shall establish criteria for evaluating the bids submitted under this section. The criteria must include:

(1) the bidder's proven ability to handle individual health benefit plans;

(2) the bidder's efficiency of claims paying procedures;

(3) an estimate of total charges for administering the pool;

(4) the bidder's ability to administer the pool in a cost-efficient manner; and

(5) the bidder's financial condition and stability.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 8, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 9, eff. January 1, 2008.

Sec. 1506.203. ADMINISTRATOR'S CONTRACT. (a) A person selected as a pool administrator shall serve in that capacity for a period specified in the contract between the pool and the pool administrator, subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the pool and the pool administrator. The term of the contract must be at least three years and may be extended, in the board's sole discretion, for up to a total term of six years.

(b) Not later than one year before the expiration date of a pool administrator's contract, including any board-authorized extensions of that contract, the board shall invite all health benefit plan issuers, including the pool administrator, to submit bids to serve as a pool

administrator for the succeeding administration period. The selection of the succeeding pool administrator must be made not later than the sixth calendar month preceding the month in which the pool administrator's contract expires.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 9, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 10, eff. January 1, 2008.

Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool administrator shall perform the functions relating to the pool that are assigned to the administrator.

(b) The assigned functions may include:

(1) performing eligibility and administrative claims payment functions for the pool;

(2) establishing a billing procedure for collection of premiums from individuals covered by the pool;

(3) performing functions necessary to ensure timely payment of benefits to individuals covered by the pool, including:

(A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) evaluating the eligibility of each claim for payment by the pool;

(4) submitting regular reports to the board relating to the operation of the pool; and

(5) determining after each calendar year the net written and earned premiums, expenses of administration, and paid and incurred losses of the pool for that calendar year and reporting that information to the board and the commissioner.

(c) The board shall determine the form, content, and time of submission of the reports required under Subsection (b)(4).

(d) The commissioner shall prescribe the forms to be used to report the information under Subsection (b)(5).

(e) The board shall determine the times at which a pool administrator is to perform the billing functions for the pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool shall pay a pool administrator for the administrator's expenses incurred in performing duties and functions as provided by the plan of operation.

(b) Except as provided by Subsection (c), the total amount of administrative costs and fees paid in a calendar year to all pool administrators may not exceed 12.5 percent of the gross premium receipts of the pool for the calendar year.

(c) The commissioner may approve payment of a higher amount, not to exceed 15 percent of the gross premium receipts of the pool for the calendar year, if the commissioner determines that the higher amount is necessary to pay the administrative costs and fees of the pool.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may assess health benefit plan issuers, including making advance interim assessments, as reasonable and necessary for the pool's organizational and interim operating expenses.

(b) The board shall credit an interim assessment as an offset against any regular assessment that is due after the end of the fiscal year.

(c) The regular assessment is the amount determined by the board under Section 1506.252 and recovered from health benefit plan issuers under Section 1506.253.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 11, eff. June 30, 2007.

Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the end of each fiscal year, the board shall determine for the preceding calendar year any net loss of the pool, including administrative expenses and incurred losses, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.2521. ANNUAL REPORT TO BOARD. Each health benefit plan issuer shall report to the board the information requested by the board, as of December 31 of the preceding year.

Added by Acts 2005, 79th Leg., Ch. 728, Sec. 11.072(a), eff. September 1, 2005.

Sec. 1506.2522. ANNUAL REPORT TO BOARD: ENROLLED INDIVIDUALS. (a) Each health benefit plan issuer shall report to the board the number of residents of this state enrolled, as of December 31 of the previous year, in the issuer's health benefit plans providing coverage for residents in this state, as:

(1) an employee under a group health benefit plan; or

(2) an individual policyholder or subscriber.

(b) In determining the number of individuals to report under Subsection (a)(1), the health benefit plan issuer shall include each employee for whom a premium is paid and coverage is provided under an excess loss, stop-loss, or reinsurance policy issued by the issuer to an employer or group health benefit plan providing coverage for employees in this state. A health benefit plan issuer providing excess loss insurance, stop-loss insurance, or reinsurance, as described by this subsection, for a primary health benefit plan issuer may not report individuals reported by the primary health benefit plan issuer.

(c) Ten employees covered by a health plan issuer under a policy of excess loss insurance, stop-loss insurance, or reinsurance count as one employee for purposes of determining that health plan issuer's assessment.

(d) In determining the number of individuals to report under this section, the health benefit plan issuer shall exclude:

(1) the dependents of the employee or an individual policyholder or subscriber; and

(2) individuals who are covered by the health benefit plan issuer under a Medicare supplement benefit plan subject to Chapter 1652.

(e) In determining the number of enrolled individuals to report under this section, the health benefit plan issuer shall exclude individuals who are retired employees who are 65 years of age or older.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 7, eff. January 1, 2006.

Sec. 1506.2523. ANNUAL REPORT TO BOARD: GROSS PREMIUMS. (a) Each health benefit plan issuer shall report to the board the gross premiums collected for the preceding calendar year for health benefit plans.

(b) For purposes of this section, gross health benefit plan premiums do not include premiums collected for:

(1) coverage under a Medicare supplement benefit plan subject to Chapter 1652;

(2) coverage under a small employer health benefit plan subject to Subchapters A-H, Chapter 1501; or

(3) coverage or insurance listed in Section 1506.002(b), (c), or (d).

Added by Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 12, eff. June 30, 2007.
Amended by:

Acts 2009, 81st Leg., R.S., Ch. 533, Sec. 7, eff. September 1, 2009.

Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The board shall recover any net loss of the pool by assessing each health benefit plan issuer an amount determined annually by the board based on information in annual statements, the health benefit plan issuer's annual report to the board under Sections 1506.2521 and 1506.2522, and any other reports required by and filed with the board.

(b) The board shall use the total number of enrolled individuals reported by all health benefit plan issuers under Section 1506.2522 as of the preceding December 31 to compute the amount

of a health benefit plan issuer's assessment, if any, in accordance with this subsection. The board shall allocate the total amount to be assessed based on the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies and on the total number of other enrolled individuals as determined under Section 1506.2522. To compute the amount of a health benefit plan issuer's assessment:

(1) for the issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy, the board shall:

(A) divide the allocated amount to be assessed by the total number of enrolled individuals covered by excess loss, stop-loss, or reinsurance policies, as determined under Section 1506.2522, to determine the per capita amount; and

(B) multiply the number of a health benefit plan issuer's enrolled individuals covered by an excess loss, stop-loss, or reinsurance policy, as determined under Section 1506.2522, by the per capita amount to determine the amount assessed to that health benefit plan issuer; and

(2) for the issuer's enrolled individuals not covered by excess loss, stop-loss, or reinsurance policies, the board, using the gross health benefit plan premiums reported for the preceding calendar year by health benefit plan issuers under Section 1506.2523, shall:

(A) divide the gross premium collected by a health benefit plan issuer by the gross premium collected by all health benefit plan issuers; and

(B) multiply the allocated amount to be assessed by the fraction computed under Paragraph (A) to determine the amount assessed to that health benefit plan issuer.

(c) A small employer health benefit plan subject to Subchapters A-H, Chapter 1501, is not subject to an assessment under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2005, 79th Leg., Ch. 824, Sec. 8, eff. January 1, 2006.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 13, eff. June 30, 2007.

Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the first day of each month during which the assessment is delinquent, plus three percent.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.
Amended by:
Acts 2007, 80th Leg., R.S., Ch. 808, Sec. 10, eff. January 1, 2008.
Acts 2007, 80th Leg., R.S., Ch. 881, Sec. 14, eff. January 1, 2008.

Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this subchapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In this section, "future losses" includes reserves for claims incurred but not reported.

(b) If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall deposit the excess in an interest-bearing account and shall use money in that account to offset future losses or to reduce future assessments.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1506.260. FUNDING FOR PREMIUM DISCOUNTS. The board shall collect penalty payments and interest paid by health maintenance organizations as provided by Section 843.342 and insurers as provided by Section 1301.137. The board may use funds collected under this section only to finance premium discounts under Section 1506.105(e-1). The board may require a health maintenance organization or an insurer to make payments under this section and make reports concerning those payments in a manner determined by the board.

Added by Acts 2009, 81st Leg., R.S., Ch. 265, Sec. 4, eff. January 1, 2010.

SUBCHAPTER G. SUBROGATION RIGHTS OF POOL

Sec. 1506.301. SUBROGATION TO RIGHTS AGAINST THIRD PARTY. The pool:

(1) is subrogated to the rights of an individual covered by the pool to recover against a third party costs for an injury or illness for which the third party is liable under contract, tort law, or other law that have been paid by the pool on behalf of the covered individual; and

(2) may enforce that liability on behalf of the individual.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 9, eff. January 1, 2006.

Sec. 1506.302. BENEFITS NOT PAYABLE; ADVANCE OF BENEFITS AUTHORIZED. (a) Under coverage provided by the pool, benefits are not payable for an injury or illness for which a third party may be liable under contract, tort law, or other law.

(b) Notwithstanding Subsection (a), the pool may advance to a covered individual the benefits provided under the pool coverage for medical expenses resulting from the injury or illness, subject to the pool's right to subrogation and reimbursement under this subchapter.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 9, eff. January 1, 2006.

Sec. 1506.303. REIMBURSEMENT OF POOL REQUIRED. (a) Subject to Section 1506.305, the amount recovered by a covered individual in an action against a third party who is liable for the injury or illness must be used to reimburse the pool for benefits for medical expenses that have been advanced under Section 1506.302.

(b) The amount of reimbursement required by this section is not reduced by the application of the doctrine established at common law relating to adequate compensation of insureds and commonly referred to as the "made whole" doctrine.

(c) Subject to Section 1506.305, the pool shall treat any amount recovered by a covered individual in an action against a third party who is liable for the injury or illness that exceeds the amount of the reimbursement required under this section as an advance against future medical benefits for the injury or illness that the individual would otherwise be entitled to receive under pool coverage.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 9, eff. January 1, 2006.

Sec. 1506.304. RESUMPTION OF PAYMENT OF BENEFITS. If the amount treated as an advance under Section 1506.303(c) is adequate to cover all future medical costs for the covered individual's injury or illness, the pool is not required to resume the payment of benefits. If the advance is insufficient, the pool shall resume the payment of benefits when the advance is exhausted.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 9, eff. January 1, 2006.

Sec. 1506.305. ATTORNEY'S FEE FOR REPRESENTATION OF POOL'S INTEREST. (a) For purposes of this section, the pool's recovery includes:

(1) the amount recovered by the pool in the action; and

(2) the amount of the covered individual's total recovery that must be used to reimburse the pool or that is treated as an advance for future medical costs under Section 1506.303(c).

(b) If the pool's interest is not actively represented by an attorney in a third-party action under this subchapter, the pool shall pay a fee to an attorney representing the claimant in the amount agreed on between the attorney and the pool. In the absence of an agreement, the court shall award to the attorney payable out of the pool's recovery:

(1) a reasonable fee for recovery of the pool's interest that may not exceed one-third of the pool's recovery; and

(2) a proportionate share of the reasonable expenses incurred.

(c) An attorney who represents a covered individual and is also to represent the interests of the pool under this subchapter must make a full written disclosure to the covered individual before employment as an attorney by the pool. The covered individual must acknowledge the disclosure and consent to the representation. A signed copy of the disclosure shall be provided to the covered individual and the pool. A copy of the disclosure with the covered individual's consent must be filed with the pleading before a judgment is entered and approved by the court. The attorney may not receive a fee under this section to which the attorney is otherwise entitled under an agreement with the pool unless the attorney complies with the requirements of this subsection.

(d) If an attorney actively representing the pool's interest actively participates in obtaining a recovery, the court shall award and apportion between the covered individual's and the pool's attorneys a fee payable out of the pool's subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to the pool as a result of each attorney's service. The total attorney's fees may not exceed one-third of the pool's recovery.

Added by Acts 2005, 79th Leg., Ch. 824, Sec. 9, eff. January 1, 2006.